

ACC Evaluation Year 2 Progress Update

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Project Summary: Mixed Methods

Quantitative Analysis

- HCPF Administrative Claims Data
- Sample Period: July, 2009 – June, 2015

Qualitative Analysis

- Interviews of Primary Care Medical Providers
- Open ended interviews using interview guide
- **Iterative process- Feedback loop into quantitative analysis**

Quantitative Analysis

- Analyzed spending comparing ACC enrollees & Control group
 - Total spending and Inpatient, Outpatient and Pharmaceutical Spending
 - Original KPIs (ED visits, readmissions, and high cost imaging)
 - By Cohort Year enrolled
- Calculated the adjusted change in ACC-related spending by:
 - Children and Adult Population
 - Year 1 – Year 4
 - RCCO
 - PCMP Practice Type
 - Practice Size
- Calculated the adjusted change in KPI performance
- Sample—Traditional ACC-eligible Enrollees
 - Exclude Denver and Mesa Counties
 - Exclude RCCO 5 (Due to selection issues with Managed Care)
 - Enrollees with less than six-months continuous enrollment
 - Enrollees who opted/dropped out of the ACC

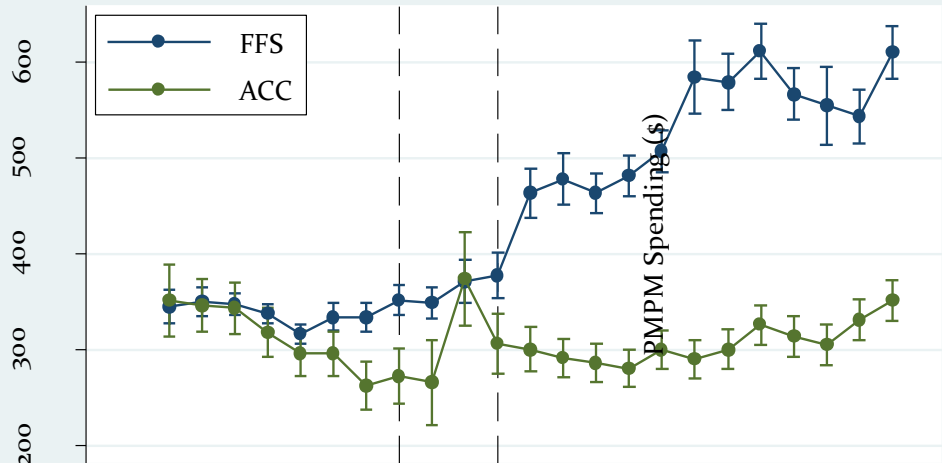
Quantitative Analysis: Approach

ACC enrolled & Control Group (Cohort 1)

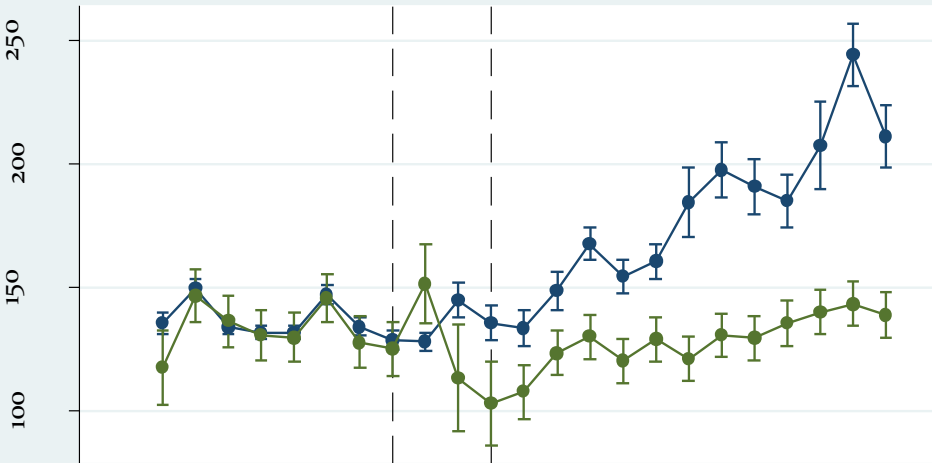
- Pre and Post analysis by enrollment year
 - Enrolled in FY2011-12
 - Control is group individuals who were eligible for the ACC but had not enrolled
- Pre-ACC period
 - 3-7 quarters of spending prior to enrollment
- Washout period (3 quarters):
 - Exclude observations from quarter initiated & the quarter before and after enrollment.
- Post-ACC Period
 - Cohort 1: 12-16 quarters of data
- Controls include CDPS Risk Scores, Demographics, Attributed Practice Characteristics

ACC and FSS Trends in Spending by Age Group

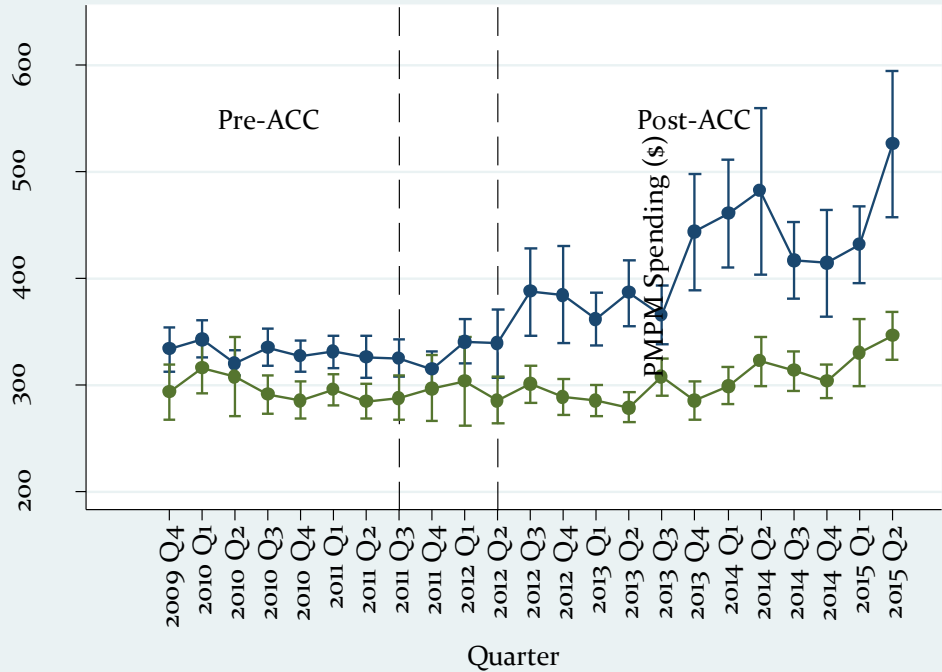
Adults
Unadjusted



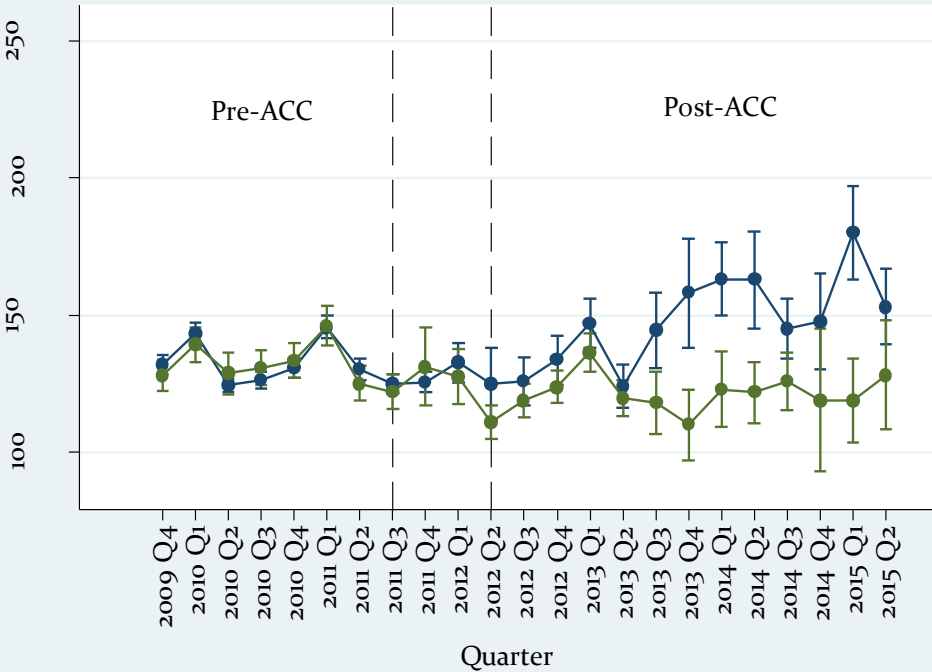
Children
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IPW Regression-Adjusted



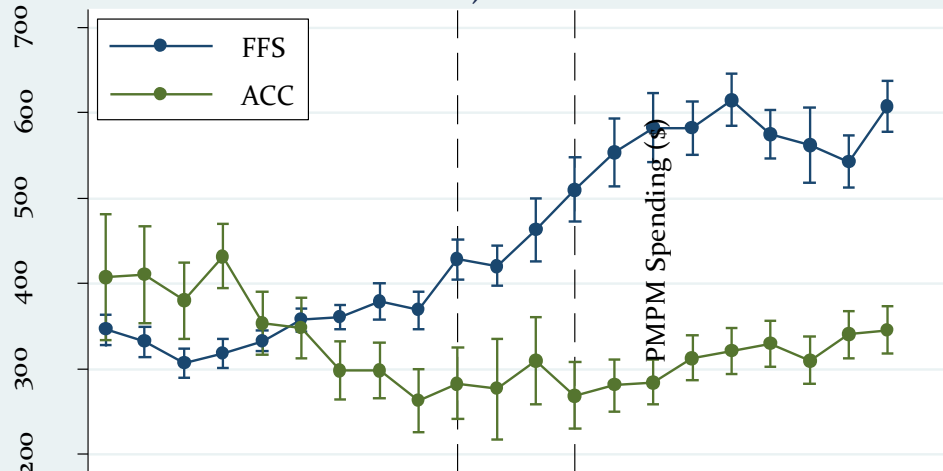
IPW Regression-Adjusted



ACC and FSS Trends in Spending by Age Group

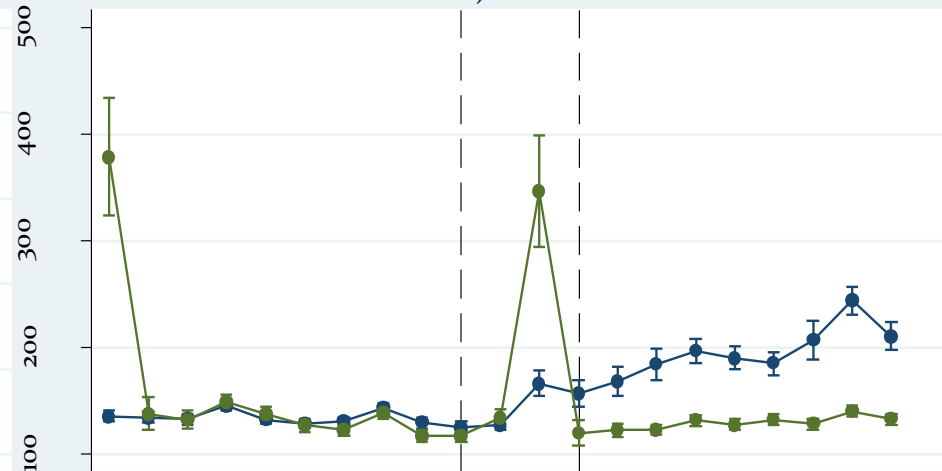
Adults

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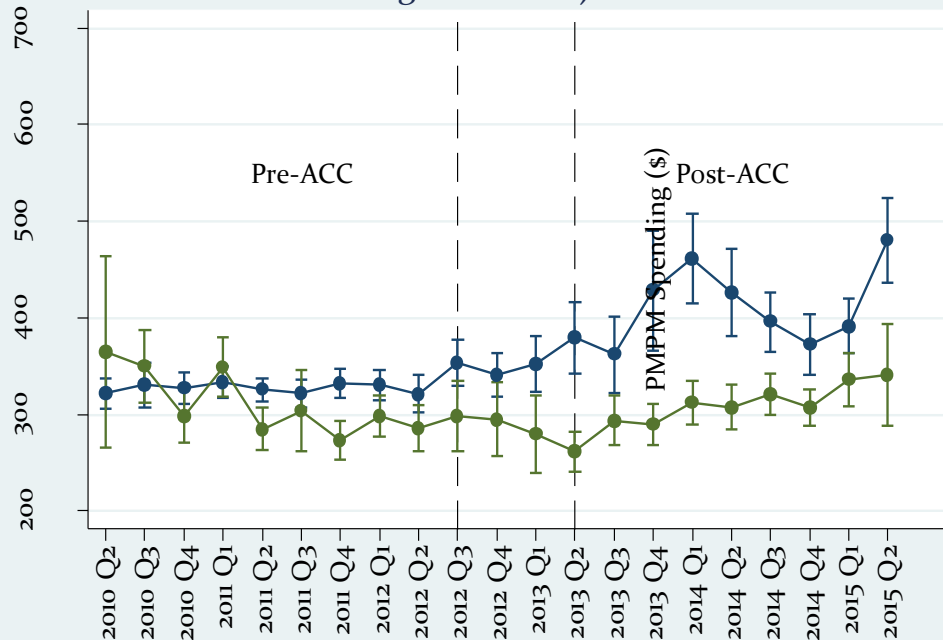


Children

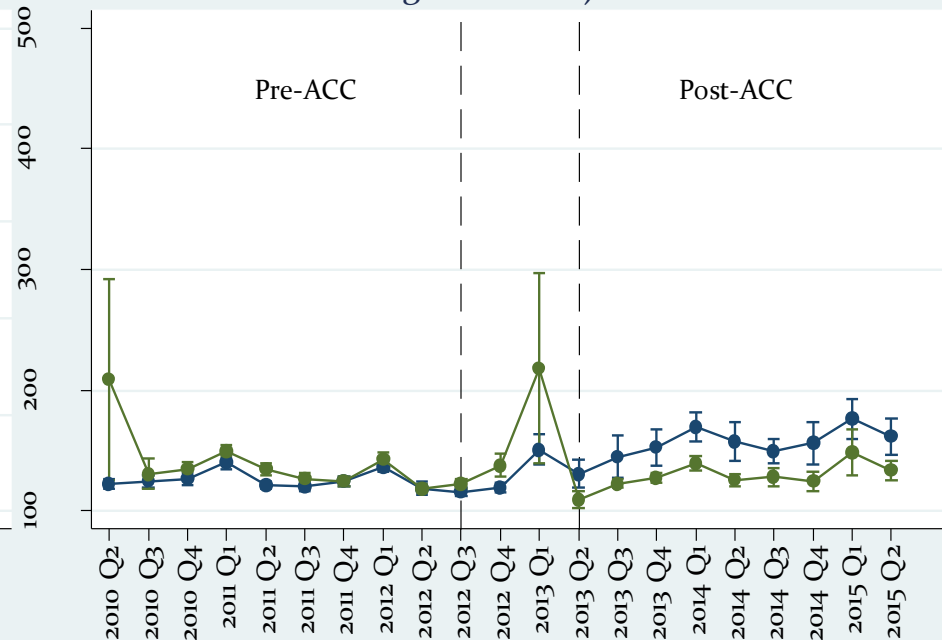
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IPW Regression-Adjusted

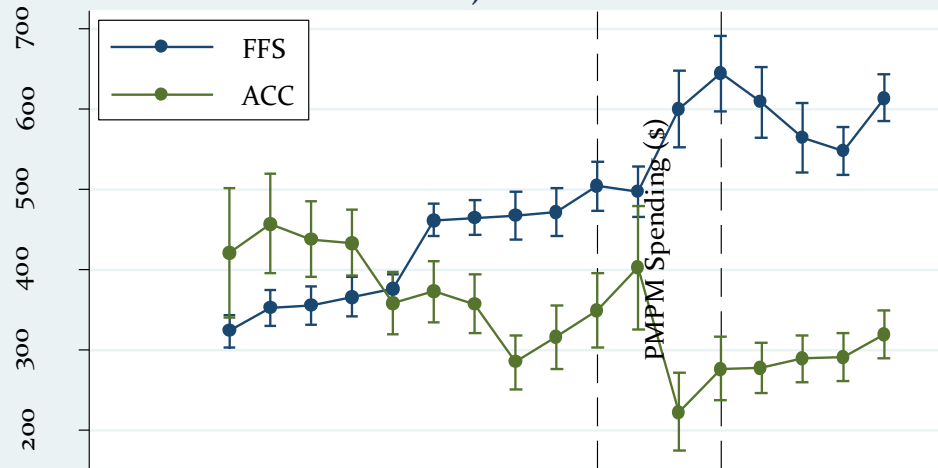


IPW Regression-Adjusted

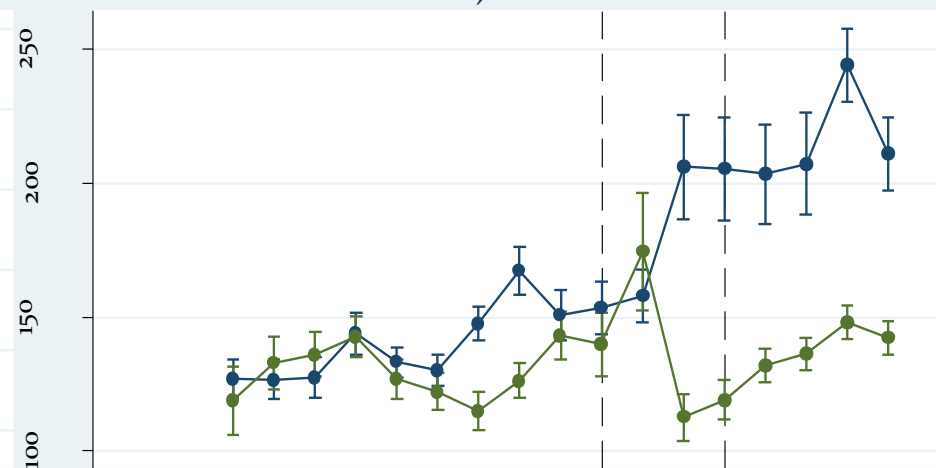


ACC and FSS Trends in Spending by Age Group

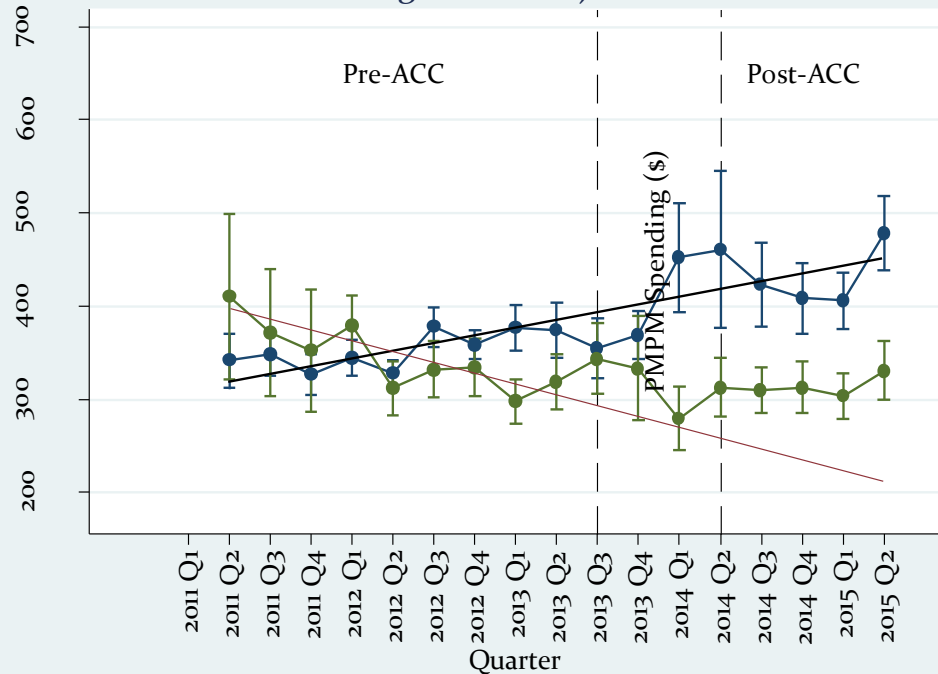
Adults
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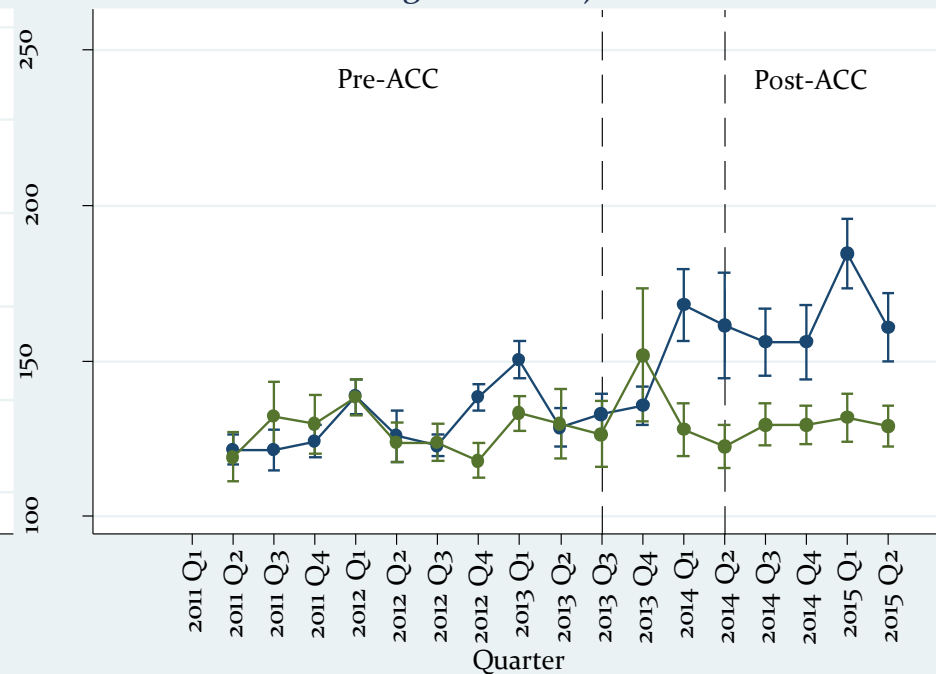
Children
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IPW Regression-Adjusted



IPW Regression-Adjusted



Results: PMPM Spending, Traditional Enrollees

	Adults	Children
	Cohort 1	Cohort 1
First Year	-38.2**	-17.1***
Second Year	-56.5**	-40.4***
Third Year	-51.8**	-29.5***
Fourth Year	-73.1**	-23.6***

Results: PMPM Spending, Traditional Enrollees

	Adults Cohort 1	Children Cohort 1
RCCO A	−57.6***	−25.7*
RCCO B	−21.3*	−16.7
RCCO C	−84.6***	−32.6*
RCCO D	−71.3***	−14.9
RCCO E	−41.8*	−34.2*
RCCO F	−59.66***	−32.7*

Results: PMPM Spending on Children

	Children (Cohort 1)	
	Any Spending	Spending Intensity (Conditional on Any Spending)
RCCO A	−0.546**	0.041
RCCO B – RCCO A	0.414*	−0.095**
RCCO C – RCCO A	0.319	−0.158***
RCCO D – RCCO A	0.201	−0.007
RCCO E – RCCO A	0.340	−0.175**
RCCO F – RCCO A	0.231	−0.126*

Results: Relative PMPM Spending on Adults

	Cohort 1 Adults by Practice Size		
	Total (Vs. Reference Group)	Any Spending	Spending Intensity (Conditional on Any Spending)
Reference: 6-24 PCMPs	PMPM (\$)	Coefficient	Coefficient
Solo	12.56	0.038	−0.040
2-5 PCMPs	2.617	0.063	0.107**
25-49 PCMPs	65.31**	0.016	0.017
50+ PCMPs	−60.56*	0.307***	−0.052
Missing PCMP size	21.66	0.271***	0.043

Summary and Conclusions

- Reductions in PMPM were sustained over time
 - First year reduction is smaller
 - Significantly larger in later years
- Savings among Children were concentrated in 3-4 RCCOs
- Results are robust to:
 - Restricted control group (FFS that didn't enroll before Jan 2014)
 - Different continuous enrollment assumptions
 - One-year
- Why are there differences across RCCOs and Populations?
 - Any utilization vs. intensity of utilization
 - 2-5 PCMP practices: Higher intensity of utilization
 - Very Large practices (50+): Higher probability of any utilization

Qualitative Study

Perspective and experiences of practices in the ACC

Brief overview of year 1 results

Updated year 2 interview guide

Preliminary year 2 results

Year 1 brief overview

General perceptions of the ACC

General enthusiasm for the ACC

- Better results for patients
- Resources for PCMPs for care coordination
- Facilitated communication
- Many areas for improvement and continued growth
- Large, medium, and small practices

Care Coordination

Variations in conceptualization and operationalization

- Risk Stratification
- Disease or topic specific
- Care coordination teams
- Smaller clinics generally reported fewer care coordination activities
- Benefits of a standard definition?
 - Additional Guidance
- PMPM not sufficient

Statewide Data Analytics Contractor

Potential of data analytics recognized but SDAC viewed skeptically

- Inappropriate attribution in SDAC
- Lag in SDAC data

Larger practices - greater sophistication with data analytics

- Still struggle with SDAC

Majority of clinics consider SDAC unusable internally

Data Driven QI*

Majority of clinics are using their own EHR and care coordination systems for data analytics and care coordination

- Some practices rely solely on their RCCO to facilitate SDAC data analysis to guide QI

Real-time access to hospital data

- Few practices have access to Health Information Exchange (CORHIO and QHN)
- Some RCCOs facilitate real-time ED visit data: inconsistent and ad-hoc
- Some practices have relationships with hospitals: inconsistent and work-intensive

Patient Education*

Understanding the medical home

Patients as partners in their care

Expansion population

- High utilizers
- Pent-up demand
- Demanding patients

Interactions with RCCOs*

Practices that operate in multiple RCCOs report differences and preferences

- Focus of ongoing qualitative work

Qualitative Wave 2 Preliminary Results

- 20-25 additional interviews
- Support from RCCOs
- KPIs
- ACC 2.0

Interactions with RCCOs

- Practices were “sensitive” about the topic
- Administrative burden of multiple RCCOs
- Lots of variability in how practices interact with RCCOs
- Preference for RCCOs to respond to practice needs

KPIs

- Changing KPIs is disruptive
 - Some clinics have structured care coordination around KPI performance
 - Some shift focus some disregard KPI
 - % improvement target creates a disincentive for already high performing clinics
 - As does regional calculation
 - Potential need for education

ACC 2.0

- Enthusiasm about openness of HCFCP to feedback
 - Perception that outreach has decreased after 2.0 delay
- Enthusiasm about greater integration of physical and behavior health
 - Questions about the details
 - Concerns about behavioral health potentially moving to FFS

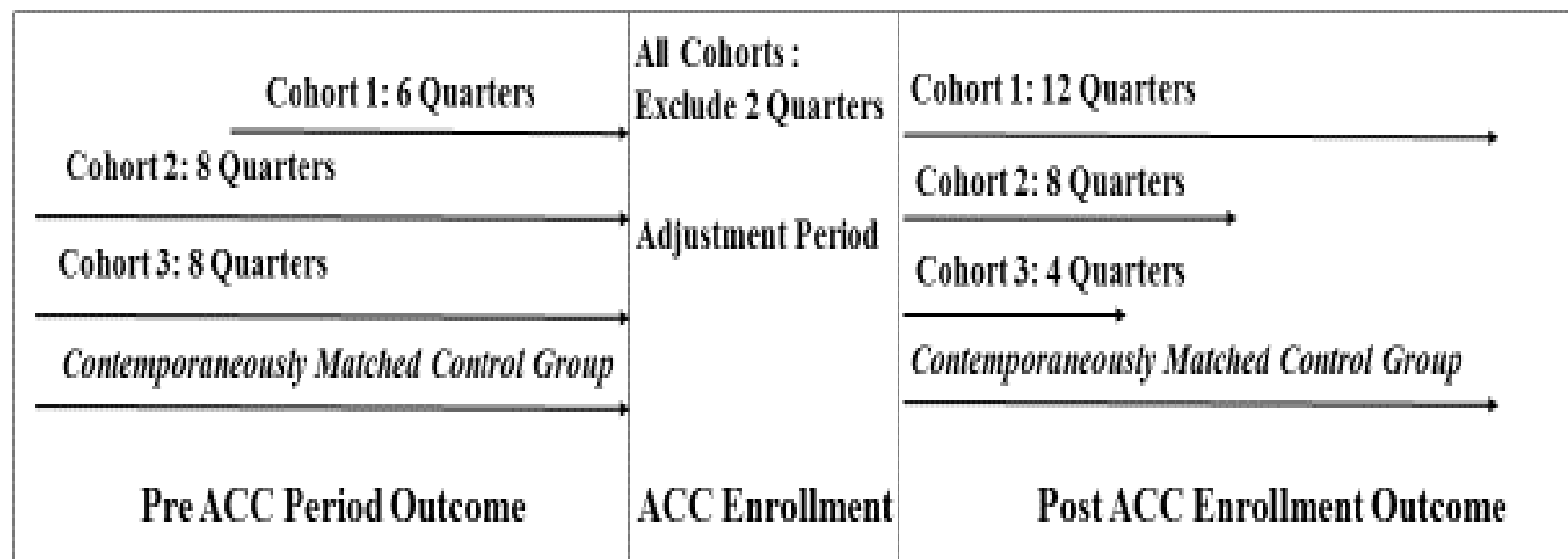
ACC 2.0

- Some enthusiasm for moving away from FFS
 - Variability in practice perceptions
- Alignment of incentives with Hospitals
- Concerns about sustainability
 - PMPM not enough
 - Many care coordination enhancements funded through grants

Appendix slides

The following slides provide details that weren't discussed during the presentation but are provided for interested persons.

Figure for Quantitative Design



Pre ACC Difference between Cohort and Control Group

$$\Delta^{Pre} = \overline{Outcome}_{Pre}^{ACC} - \overline{Outcome}_{Pre}^{Control}$$

Post ACC Difference between Cohort and Control Group

$$\Delta^{Post} = \overline{Outcome}_{Post}^{ACC} - \overline{Outcome}_{Post}^{Control}$$

$$\text{Difference in Differences Estimate} = \Delta^{Post} - \Delta^{Pre}$$

Controlling for Selection into ACC

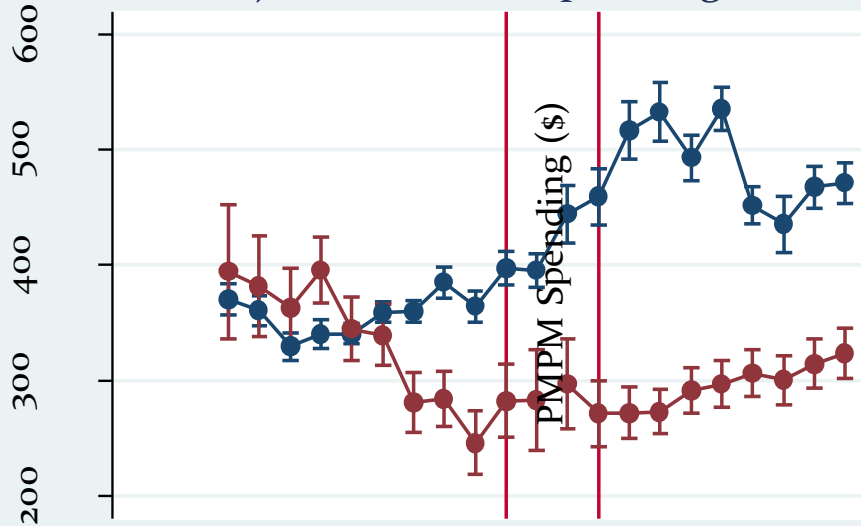
- Attribution Process
 - Replicated attribution based on prior 12 month E&M visits for *all* ACC eligible beneficiaries
 - Assigned a fixed effect based on “pseudo” attributed provider
 - Controls for selection related to enrollee —primary care relationship (future PCMP)
- Propensity score weighting
 - Model probability of ACC enrollment using “pseudo” attributed physician and beneficiary characteristics
 - Provider type and Patient language, race, age
 - Weight regressions using inverse probability weights from propensity score
 - Control for selection on observable characteristics

Spending Specification

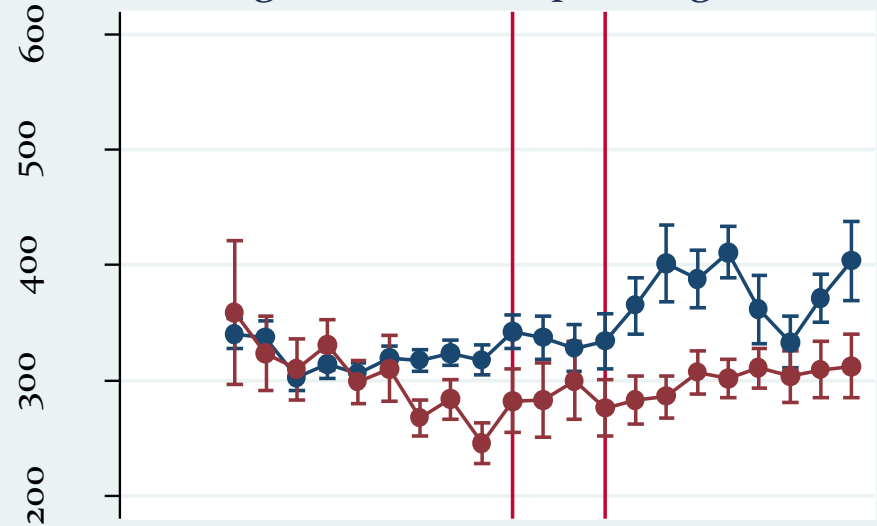
- “Two-part model”
 - Controls for prevalence of \$0 spending (i.e. no utilization)
 - Part 1: Probability of any utilization with Logit specification
 - Part 2: Spending conditional on any utilization
- Separate estimates for Standard and Dual enrollees
- Separate Estimates by Cohort
- Adjust for comprehensive set of risk-adjusters and patient characteristics

ACC (Red) and FFS (Blue) Adults: Cohort 2

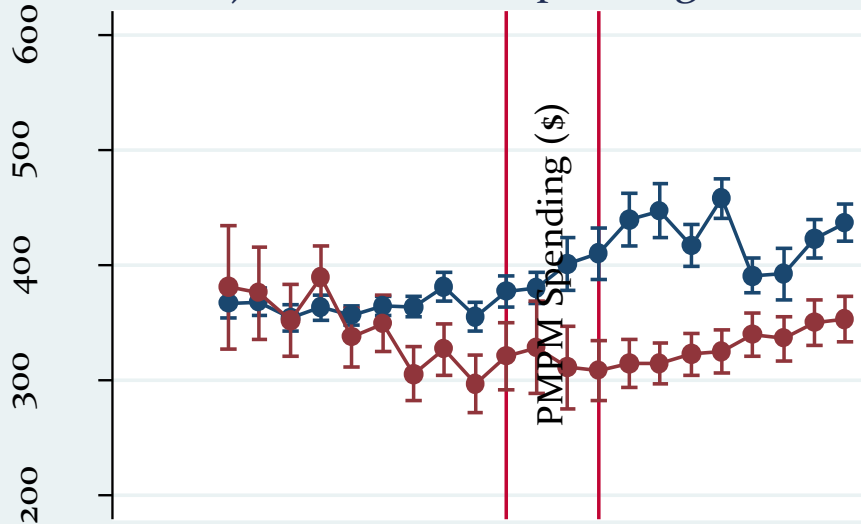
Unadjusted PMPM Spending



Weighted PMPM Spending



Adjusted PMPM Spending



Adjusted and Weighted PMPM Spending

